

Michigan Department of Community Health  
**Board of Dentistry**  
P.O. Box 30670  
Lansing, Michigan 48909  
(517) 335-0918

## **DENTAL SPECIALTY CERTIFICATION INSTRUCTIONS**

Authority: P.A. 368 of 1978, as amended  
This form is for information only.

**NOTE:** It is your responsibility to have all required documentation sent to the Board of Dentistry. Questions regarding your application can be directed to the Michigan Board of Dentistry at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

### **GENERAL INSTRUCTIONS**

Please mark the appropriate type of licensure for which you are applying. Read all instructions carefully and answer all questions on the application. Please provide details on a separate sheet if necessary. Failure to correctly complete the application in its entirety may result in a delay in the processing of your application.

### **SPECIALTIES RECOGNIZED BY THE MICHIGAN BOARD OF DENTISTRY:**

1. Oral (Maxillofacial) Surgery
2. Orthodontics
3. Prosthodontics
4. Periodontics
5. Pediatric Dentistry
6. Endodontics
7. Oral Pathology - No exam required.

### **REQUIREMENTS FOR ELIGIBILITY FOR SPECIALTY CERTIFICATION:**

1. Must hold a current Michigan dental license
2. Must have completed an ADA accredited graduate program in the specific specialty applied for and have the "Certification by Specialty Program Administrator" form and final, official transcripts submitted to this office directly by the hospital or school of dentistry providing the training.
3. Must file an application and fee with the Michigan Board of Dentistry for specialty certification
4. Must have either, taken and passed the Michigan clinical and written specialty examination for your specialty or have American Board diplomate status in your specialty. Verification of diplomate status must be sent to this office directly from the appropriate agency.
5. All Michigan Specialty Examinations contain a minimum of two parts- Clinical and Written. If you have taken and passed the written portion of the American Board examination in your specialty, the Michigan written examination requirements may be waived. We must receive verification that you have passed the American Board written examination directly from the American Board.

Applicants made eligible to sit for the Michigan Specialty Examination will receive a brochure with specific instructions and requirements for the Specialty Examination.

6. If you are applying for certification by endorsement, complete PART I of the Certification for Licensure by Endorsement form and mail it to the state from which you are endorsing. PART II will be completed by that state. (The licensing agency of that state may charge a fee for this service. You may wish to contact them before you submit the form.)

7. If you have taken another state examination, please arrange to have that state's testing agency forward a copy of the examination specifications and your scores to the Michigan Board of Dentistry. The examination you took will be evaluated by the Michigan Board to see if it is equivalent to the Michigan Specialty examination. You will be notified by the Board's decision to accept either the examination you took or require that you pass all or part of the Michigan Specialty examination.
8. If you do not hold a current license in the state you are endorsing from, you must submit a Verification of Licensure form indicating possession of a current license in another state before you will be considered for licensure by endorsement in Michigan.
9. If you are or have been licensed in more than one state, complete the top portion of the Verification of Licensure form and forward it to all other states in which you are currently or have ever been licensed.

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.

**Board of Dentistry**

P.O. Box 30670  
Lansing, MI 48909  
(517) 335-0918

DCH/LDN-025 (03/04)

**APPLICATION FOR DENTAL SPECIALTY CERTIFICATION**

Authority: Public Act 368 of 1978, as amended  
if this form is not completed, a license will not be issued.

Type or Print Only

**I AM APPLYING FOR SPECIALTY CERTIFICATION BASED ON THE FOLLOWING (Check One):**

- ☐ Examination (Michigan Written and Clinical), Fee: \$345.00 71-2901-11
- ☐ Examination (Michigan Clinical Only), Fee: \$245.00 71-2901-28  
(You must have taken and passed the American Board written exam. The American Board must verify your passing score to this office.)
- ☐ American Board Diplomat Status - Fee: \$45.00 71-2901-11
- ☐ Endorsement - Fee: \$45.00 71-2901-11  
(Only those applicants who have been issued a license/certificate by another U.S. Jurisdiction in their specialty may apply for endorsement.)

Board Use Only

Specialty License Number

CS License Number

Date of Licensure

**I AM APPLYING FOR THE FOLLOWING SPECIALTY CERTIFICATIONS (A separate application must be submitted for each specialty.)**

- ☐ Endodontics    ☐ Periodontics    ☐ Prosthodontics  
☐ Orthodontics    ☐ Pediatric Dentistry    ☐ Oral Maxillofacial Surgery    ☐ Oral Pathology

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application.  
**DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan DDS Permanent I.D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	
Have you ever held a health professional license in Michigan?		
<input type="checkbox"/> No <input type="checkbox"/> Yes		

**Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| 1. Have you ever been convicted of a felony?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you been treated for substance abuse in the past 2 years?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have you had one or more malpractice settlements, awards, or judgments totaling \$200,000 or more in any consecutive 5 year period?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you ever had a federal or state health professional license or certification revoked, suspended, or otherwise disciplined; been denied a specialty license; or currently have disciplinary action pending against you? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Name			
8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
9. Do you hold or have you ever held a dental specialty license or certification in any state? List each state, the license number, the date issued and how the license was obtained (either endorsement or examination). <b>You must have each board verify licensure directly to this office. (Attach additional sheets, if necessary)</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
State	License Number	Date of Issue	How obtained (Endorsement or examination)

**Provide a complete chronological record of your educational preparation. Attach additional sheets if necessary.**

Name and Address of Institution	Dates of Attendance From                      To	Degree

Name of School Granting Specialty Degree or Certificate	Did you receive a (circle one)	Graduation Date
Name of Specialty	Degree      Specialty Certificate	

Have you taken an American Board Examination in your specialty?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Clinical <input type="checkbox"/> Written
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Date(s) of Examination(s)	<input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Pass <input type="checkbox"/> Fail
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Do you have American Board diplomat status in your specialty?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**CERTIFICATION**

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date
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## Michigan Department of Community Health

## Board of Dentistry

P.O. Box 30670

Lansing, MI 48909

(517) 335-0918

## CERTIFICATION OF SPECIALTY PROGRAM

Authority: Public Act 368 of 1978, as amended  
 If this form is not completed, a certification will not be issued.

## SECTION I - APPLICANT INFORMATION

Instructions: Applicant complete Section I. Type or print your name exactly as it appears on your application. Send this form to the Program Administrator for your specialty program for completion of Section II and then have the Administrator send it directly to the Board.

First Name	Middle Name	Last Name
Social Security Number		Date of Birth
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

## SECTION II - CERTIFICATION OF SPECIALTY PROGRAM

Instructions: Administrator complete Section II and return it directly to the Michigan Board of Dentistry at the address given above.

Name of Hospital or School
Street Address of Hospital or School
City, State and ZIP Code

I do hereby certify that \_\_\_\_\_ completed all  
 Applicant's Name

requirements at \_\_\_\_\_ for a \_\_\_\_\_  
 Name of Hospital or School of Dentistry Name of Specialty

☐ Degree ☐ Certificate on \_\_\_\_\_  
 Month\Date\Year

\_\_\_\_\_  
 Signature of Program Administrator

\_\_\_\_\_  
 Date of Signature

\_\_\_\_\_  
 Print or Type Name and Title of Program Administrator

( Seal of School or Hospital )

**NOTE: This certification may not be dated and submitted more than fifteen (15) days prior to the completion of the specialty program.**

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American Disabilities Act, you may make your needs known to this agency.

**Board of Dentistry**

P.O. Box 30670

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**CERTIFICATION FOR SPECIALTY CERTIFICATION BY ENDORSEMENT**

Authority: Public Act 368 of 1978, as amended.

If this form is not completed, certification will not be issued if applying by endorsement.

**PART I: To be completed by applicant and forwarded to the licensing agency of the state from which you are endorsing.**

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	
Street Address		
City	State	ZIP Code
Daytime Telephone Number	Previous Name Used (If Applicable)	

Type of Specialty	License/Certification Number	
Specialty School Attended	Graduation Date	
Street Address		
City	State	ZIP Code

**PART II: To be completed by the licensing agency of the state from which you are endorsing your specialty license/certificate.**

The applicant listed above has applied for specialty certification in Michigan based, in part, on his/her licensure/certification in your state. Please complete Part II of this form to assist us in processing his/her application and return it directly to the Michigan Board of Dentistry at the address above.

1. Which Do You Issue? (Check One): ☐ SPECIALTY LICENSE ☐ SPECIALTY CERTIFICATION

Name of Licensed/Certified Specialist

License/Certificate Number

Date Issued

2. Indicate the licensure requirements that were in effect at the time applicant was licensed/certified in your state. (Respond yes or no and elaborate if necessary.)

a. Degree: \_\_\_\_\_

b. Accredited School: \_\_\_\_\_

c. Specialty Exam: Regional \_\_\_\_\_ State Constructed \_\_\_\_\_

d. Other (Explain): \_\_\_\_\_

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American Disabilities Act, you may make your needs known to this agency.

Name 

**"SCORE" MEANS A NUMBER, PERCENT, OR PASS/FAIL. PLEASE GIVE AS MUCH INFORMATION REGARDING THIS EXAMINATION AS POSSIBLE.**

## 3. SPECIALTY WRITTEN/COMPREHENSIVE EXAMINATION

EXAMINATION SUBJECT	SCORE

## 4. SPECIALTY CLINICAL EXERCISE EXAMINATION

EXAMINATION SUBJECT	SCORE

5. Please describe the passing score rule that was in effect at the time the above exam was taken. \_\_\_\_\_

\_\_\_\_\_

6. Please describe the criteria used to determine the passing level. \_\_\_\_\_

\_\_\_\_\_

7. Specialty Status: ☐ Current ☐ Lapsed ☐ Inactive Expiration Date: \_\_\_\_\_

8. Has the applicant ever had a license revoked, suspended, or otherwise disciplined; been denied a license; or currently have a disciplinary action pending? If yes, please attach certified copies of any action(s). ☐ Yes ☐ No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
State Board

\_\_\_\_\_  
Printed or Typed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

## Michigan Department of Community Health

## Bureau of Health Professions

P.O. Box 30670

Lansing, MI 48909

## VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

**PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.**

Check the profession for which you are requesting verification.		
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Nursing	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Counseling	<input type="checkbox"/> Nursing Home Adm.	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physician's Assistants
<input type="checkbox"/> Marriage & Family Therapy	<input type="checkbox"/> Optometry	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Medicine	<input type="checkbox"/> Osteopathy	<input type="checkbox"/> Psychology
<input type="checkbox"/> Sanitarians	<input type="checkbox"/> Social Work	<input type="checkbox"/> Veterinary
First Name	Middle Name	Last Name
Previous Names Used	Date of Birth	U. S. Social Security Number
State Board	License Number	Date of Issue

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State. Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

**PART II: To be completed by the State Licensing Board.**

Basis for Issuance of License:		Type of License:
<input type="checkbox"/> Examination - Please indicate type of exam (National, Regional, State, etc.)	<input type="checkbox"/> Endorsement - Please indicate name of state	
License Status	Original Issue Date	Expiration Date
<input type="checkbox"/> Current <input type="checkbox"/> Lapsed <input type="checkbox"/> Inactive		
Has the applicant incurred any formal or informal actions in your State?		
<input type="checkbox"/> No <input type="checkbox"/> Yes - If Yes, Please attach certified copies of any actions.		
Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**CERTIFICATION**

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

Signature

Date

Type or Print Name

(S E A L)

Title

Full Name of Licensing Board